MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85a

03796

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Joan Louise Abbott

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

6.(b) Name of husband or wife: ✓
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 4 1941

8. AGE: Years 4 | Months 3 | Days 7 | If less than one day: hrs. min.

9. Birthplace: Manchester, Md. (Town, county, and state)

10. Usual occupation: ✓

11. Industry or business: ✓

FATHER
12. Name: E. Ray Abbott
13. Birthplace: Maryland

MOTHER
14. Maiden name: Willa J. Stump
15. Birthplace: Maryland

16. Informant: E. Ray Abbott
Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-14-45 (month) (day) (year)
Cemetery or crematory: cemetery
Location: Greenmount, Md.

18. Funeral director: Jacob Wisbie Sons
Address: Manchester, Md.

19. Apr. 13 1945 Mrs. W. R. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 1945, at 10:00 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1945, to April 11 1945
and that I last saw her alive on April 11 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to: Convulsions	1 day
Due to: Congenital Cerebral Diplegia	4y 3mo
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Minnie C. Partinfield M. D. or other
Address: Hampstead, Md. Date signed: 4-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03797

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 2 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 576 W. Preston St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: ALICE ORENE BARNES

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 21, 1923

8. AGE: Years	Months	Days	If less than one day
22	2	18	hrs. min.

9. Birthplace: Youngstown, Ohio (Town, county, and state)
10. Usual occupation: Factory Worker
11. Industry or business

FATHER
12. Name: Frederick Barnes
13. Birthplace: Armour, N.C.

MOTHER
14. Maiden name: Lula Manuel
15. Birthplace: Currie, N.C.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial, cremation, or removal. Which?: Burial Date thereof: April 12th (month) (day) (year) 45
Cemetery or crematory: Mt Calvary
Location:

18. Funeral director: Elmer O. Wilson
Address: 1000 N. Brantley

19. (Date rec'd by registrar): April 8, 1945
Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8, 1945, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6, 1945 to April 8, 1945 and that I last saw her alive on April 8, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1944
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 4-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03798

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs., 7 months, 3/4 day
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 16 yrs., 7 months, 3/4 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Baltimore City
City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Samuel Bernardo

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
62			hrs. min.

9. Birthplace Italy (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Unk
13. Birthplace

MOTHER
14. Maiden name Unk
15. Birthplace

16. Informant Mr. Dan Marshall, friend
Address University Hospital, Dental Dept Baltimore, Maryland

17. Burial, Cremation, or Removal? Burial Date thereof April 13, 1945 (month) (day) (year)
Cemetery or crematory Springfield State Hospital Cem.
Location Sykesville, Md.
18. Funeral director C. Harry Wenz
Address Sykesville, Md.
19. April 13, 1945 (Date rec'd by registrar) C. Harry Wenz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1945, at 3:40P, M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7, 1945, to April 11, 1945
and that I last saw him alive on April 11, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	1 years
Due to:	
Due to:	
Other conditions: Dementia Praecox (Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edward F. Kernan M. D. or other
Address Sykesville, Md Date signed 4-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03799

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11½ days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 11½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2201 Gough Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Bertha Bielat

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 8. 1918

8. AGE: Years	Months	Days	If less than one day
26	6	7	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Seamstress

11. Industry or business:

FATHER — 12. Name: John Leon Bielat

13. Birthplace: Poland

MOTHER — 14. Maiden name: Eva Ksiazk

15. Birthplace: Buffalo, New York

16. Informant: Eva Harris, mother

Address: 2201 Gough Street, Balto., Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 4/20/45 (month) (day) (year)

Cemetery or crematory: St. Stanislaus

Location: Dundalk Ave.

18. Funeral director: Stephen J. Fidkowski

Address: 1600 S. Kenwood Ave.

19. 4/19/45 (Date rec'd by registrar) A. W. Medick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 1945 at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-5 1945 to 4-16 1945 and that I last saw her alive on 4-16 1945

	DURATION
Immediate cause of death: Spontaneous Pneumothorax	3 hrs.
Due to: Pulmonary Tuberculosis.	4+ mos.
Due to:	
Other conditions: Schizophrenia	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Edward F. Kerman M. D. or other

Address: Sykesville, Md. Date signed: 4-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (43-M)

CERTIFICATE OF DEATH

03800

Reg. Diet. No. 82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: near Ridgeville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural--Ridgeville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. Mt. Airy, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 1

3.(a) FULL NAME: LEE O. BOONE

3.(b) Social Security Number: 217-01-5428

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 20, 1888

8. AGE: Years	Months	Days	If less than one day
56	5	12	hrs. min.

9. Birthplace: Frederick Co. Maryland
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business

FATHER
12. Name: Marshall O. Boone
13. Birthplace: Maryland

MOTHER
14. Maiden name: Josephine Wilson
15. Birthplace: Maryland

16. Informant: Miss Blanche L. Boone
Address: Military Rd. Frederick, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-5-45 (month) (day) (year)
Cemetery or crematory: Linganore
Location: Unionville, Fred. Co. Md.

18. Funeral director: C.M. Waltz
Address: ~~April 4, 1945~~ Winfield, Md.

19. April 4th, 1945 (Date rec'd by registrar) Wm D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 1945, at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: Apr 2-45
Where did injury occur? Mt. Airy (City or town) Frederick (County) Md (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Gun Shot Wound Injured at work? No

23. SIGNATURE: James T. Thomas, Deputy Medical Examiner M. D. or other
Address: Frederick Md Date signed: 4/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 03801 76

Within Corporate Limits

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Westminster Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred: Charles Carroll Hotel, E. Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Ridgewood Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Green Spring Valley, Balto. Co.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Seymour Morse Briggs

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Ada Scott Briggs
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 12, 1880

8. AGE: Years	Months	Days	If less than one day
65	1	6	hrs. min.

9. Birthplace: Franklin, Vermont
(Town, county, and state)
10. Usual occupation: Flour Broker
11. Industry or business: Wholesale flour industry
FATHER 12. Name: Darwin Briggs
13. Birthplace: Vermont
MOTHER 14. Maiden name: Harriet A. Davidson
15. Birthplace: Richmond Va.
16. Informant: Mrs. Ada Scott Briggs
Address: Box #102 Ridgewood Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: April 19 45 (month) (day) (year)
Cemetery or crematory: Oak Grove Cemetery
Location: LaCrosse, Wisconsin
18. Funeral director: J. E. Myers, Jr.
Address: Westminster, Md.
19. 4/18 19 45 (Date rec'd by registrar) J. E. Meadows Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 18th 1945 at 3 a M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Apr 12 1945 to Apr 18 1945
and that I last saw him alive on Apr 17 1945

	DURATION,
Immediate cause of death: Acute Cardiac Dilatation	after minutes
Due to: cardiac decompensation	5 wks
Due to: Chronic Myocarditis	6 mos
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas. R. Fouts M.D.
M. D. or other
Address: Westminster Date signed: 4/18/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03802

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 30 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 913 N. Bond St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MURPHY BROWN

3.(b) Social Security Number: 213-09-3000

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Lindsey Brown
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): Feb. 16, 1900

8. AGE: Years	Months	Days	If less than one day
45	2	11	...hrs. ...min.

9. Birthplace: Littleton, N.C.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Bob Brown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mandie Palmer
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Stiffed (Burial, cremation, or removal. Which?) Date thereof 4/30/45 (month) (day) (year)
Cemetery or crematory
Location: Littleton, N.C.
18. Funeral director: Leroy O. Wilson
Address: 1011 Brantley ave

19. April 27, 19 45 (Date rec'd by registrar) Albert R. Swankhart Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27, 19 45 at 7:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28, 19 44 to April 27 19 45 and that I last saw him alive on April 27, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 4-27-45

M

I

T

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14a

CERTIFICATE OF DEATH

03803

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown, (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (a) FULL NAME J. Earl Clem

3. (b) Social Security Number 717-07-6784

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Alice Hape Clem

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) February 23, 1896

8. AGE: Years	Months	Days	If less than one day
49	1	19	... hrs. ... min.

9. Birthplace Ladiesburg, Frederick Co., Md. (Town, county, and state)

10. Usual occupation Track Foreman

11. Industry or business Railroading

FATHER 12. Name Jesse D. Clem

13. Birthplace Md.

MOTHER 14. Maiden name Emma Sluss

15. Birthplace Md.

16. Informant Mrs. Earl Clem

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 14, 1945 (month) (day) (year)

Cemetery or crematory Haugh's Cemetery

Location Nr. Ladiesburg, Md.

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19. April 13 1945 (Date rec'd by registrar) Ethel M Mehring Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945, at 1:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...

and that I last saw h... alive on ... 19 ...

	DURATION
Immediate cause of death Coronary Disease	—
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings of operations — Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE James T. Marsh Deputy Medical Examiner M. D. or other

Address New Windsor Md Date signed Apr 11-45

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

03804

CERTIFICATE OF DEATH

Reg. Dist. No. 71

Carroll County Health Dept

1. PLACE OF DEATH:

County CARROLL

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 96 Penna Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Annie K. Cummings

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	married

8.(b) Name of husband or wife Theodore Cummings

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 2, 1869

8. AGE:	Years	Months	Days	If less than one day
	76	0	2	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER — 12. Name Pius Babylon

13. Birthplace Md.

MOTHER — 14. Maiden name Missouri Rinehart

15. Birthplace Md.

16. Informant Theodore Cummings

Address 92 Penna Ave., Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 26, 1945 (month) (day) (year)

Cemetery or crematory Baust

Location Tyrone, Md.

18. Funeral director C.O. FUSS & SON

Address Taneytown, Md.

19. 4/24 (Date rec'd by registrar) 1945 O. Dayton Fogle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23rd 1945 at 12.10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1942 1945 to Apr 23 1945 and that I last saw h[illegible] alive on Apr 23 1945

Immediate cause of death	DURATION
acute cardiac Dilatation	2 hrs
Due to myocarditis chronic	12 mo
Due to Diabetes Mellitus	4 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas R Fouts M.D. M. D. or other

Address Westminster Md. Date signed 4/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

(T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

03805

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 2 mo., 18 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? Sykesville, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Huffer Ellsworth Davis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): April 3, 1901

8. AGE: Years	Months	Days	If less than one day
44	0	25	hrs. ... min.

9. Birthplace: Hagerstown Wash. Co. Md. (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: agriculture

FATHER
12. Name: John R. Davis
13. Birthplace: Hagerstown, Md

MOTHER
14. Maiden name: Bessie L
15. Birthplace: Hagerstown, Md

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/30/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Boonsboro, Md
18. Funeral director: Richard K. Coffman
Address: Hagerstown Md.

19. April 28 1945 C. Harry Wiles Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28 1945 at 1:00a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18 1944 to April 28 1945 and that I last saw him alive on April 27 1945

Immediate cause of death: Chronic myocarditis and myocardial degeneration — DURATION: Prior to April 23, 1945

Due to:

Due to:

Other conditions: Schizophrenia, catatonic type, prior to January 1944
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Robert Bertrand May, M.D.
23. SIGNATURE: Robert Bertrand May M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed 4-28-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

63806

Reg. Diat. No. 71

1. PLACE OF DEATH:

County Carroll

City or town Uniontown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Rural

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Uniontown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Elizabeth Davis

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband ~~or wife~~ James E Davis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 21 - 1861

8. AGE: Years	Months	Days	If less than one day
84	1	2	..... hrs. ..... min.

9. Birthplace Carroll County, Md (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER 12. Name Granville Stuyey

13. Birthplace Maryland

MOTHER 14. Maiden name Rebecca Flickinger

15. Birthplace Maryland

16. Informant Mrs. Henry O. Sitting

Address Uniontown Rural Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 26-1945 (month) (day) (year)

Cemetery or crematory Methodist Cemetery

Location Uniontown Md

18. Funeral director H. H. Hartzler & Sons

Address Union Bridge & New Windsor Md.

19. Apr 25 1945 Margaret Ringler

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1945 at 11.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-10- 1945 to 4-23- 1945

and that I last saw h.. alive on 4-23- 1945

Immediate cause of death	DURATION
Pulmonary Edema	
Due to Chronic myocarditis	
Due to Duration 6 months or more	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Legg M. D. or other

Address Uniontown Md Date signed 4-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (931)

03807

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Sykesville R.D. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Hanson Dorsey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Olivia Audrey Warfield

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1879

8. AGE: Years	Months	Days	If less than one day
66	2	28	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business State Roads Comm.

FATHER 12. Name William Dorsey

13. Birthplace Md.

MOTHER 14. Maiden name Mary Featherwood

15. Birthplace Md.

16. Informant Mrs. Olivia Dorsey

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 22, 1945 (month) (day) (year)

Cemetery or crematory Freedom Cemetery

Location Freedom, Carroll Co., Md.

18. Funeral director C. Harry Weer

Address Sykesville, Md.

19. April 19, 1945 C. Harry Weer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 1945, at 4:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Family Physician, 19.. to 4/19, 1945 and that I last saw h.. alive on 4/18/45, 19..

Immediate cause of death	DURATION
Chronic myocarditis with decompensation	
Due to Chr. arteriosclerosis	
Due to senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. H. Lawson, M.D. (M. D. or other)

Address Sykesville, Md. Date signed 4/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21st)

03808

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro infants give residence of mother)
State Md. County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 19 St Johns
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Celia E Baugh

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife H. A. E Baugh
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 1 1887

8. AGE:

Years	Months	Days	If less than one day
68	0	24	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name William Bish
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Not Known
15. Birthplace " "

16. Informant H. A. E Baugh
Address Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 28-1945 (mooth) (day) (year)
Cemetery or crematory Wesley Cemetery
Location Hampstead Md.
18. Funeral director N. Bankard & Son
Address Westminster Md.
19. 4/26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1945 at 1245 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May - 1935 to April 25 1945
and that I last saw h. alive on April 25 - 1945

Immediate cause of death	DURATION
Myocarditis (chr.)	
Nephritis (chr.)	
Due to	
Due to	
Other conditions	

(Include pregnoocy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Jeanette M.D.
M. D. or other
Address Westminster Md Date signed 4-25-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03809

Reg. Dist. No. 81.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Roger Cook Fritz

3.(b) Social Security Number: 213-03-1007

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edith Dayhoff Fritz
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 25 1889

8. AGE:

Years	Months	Days	If less than one day
55	7	20	..... hrs. ..... min.

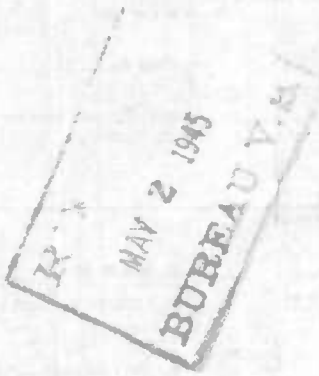
9. Birthplace: New Windsor, Carroll Co. Md.
(Town, county, and state)
10. Usual occupation: Mill Operator
11. Industry or business: Cement Plant
FATHER 12. Name: Milton Fritz
13. Birthplace: Maryland
MOTHER 14. Maiden name: Kathleen Cook
15. Birthplace: Maryland
16. Informant: Mrs Edith Fritz
Address: Union Bridge Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 18 1945 (month) (day) (year)
Cemetery or crematory: Pipe Creek Cemetery
Location: New Windsor-Uniontown Road
16. Funeral director: D.D.Hartzler & Sons
Address: Union Bridge & New Windsor Md
19. Apr. 17 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1945, at 12:25 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 15 1945 to April 15 1945
and that I last saw h... alive on April 15 1945
Immediate cause of death: Myocardial infarction — DURATION: 2 1/2 hrs.
Due to: Coronary occlusion — DURATION: " "
Due to: — DURATION:
Other conditions: Ventricul Lesions — DURATION:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edwin L. Seigman M. D. or other
Address: Union Bridge, Md. Date signed: 4/15/45


MAY 2 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

03810

Reg. Diat. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 1 mo., 10 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 1 yr., 1 mo., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unk

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Karl Gartner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Unk

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 13, 1874

8. AGE: Years	Months	Days	If less than one day
70	10	5	hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Tailor

11. Industry or business:

FATHER — 12. Name: Unk

13. Birthplace: Germany

MOTHER — 14. Maiden name: Unk

15. Birthplace: Germany

16. Informant: Springfield State Hosp. records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 21, 1945 (month) (day) (year)

Cemetery or crematory: Mount Carmel Cem.

Location: Baltimore, Md.

18. Funeral director: Leonard J. Rusk

Address: 5305 Harford Rd.

19. April 18, 1945 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18, 1945, at 1:30p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25, 1944 to April 18, 1945 and that I last saw him alive on April 18, 1945

Immediate cause of death	DURATION
Arteriosclerosis	4 yrs.
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis (Include pregnancy within 3 months of death)	4 yrs.

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.

Robert Bertrand May, M.D. M. D. or other

Address: Springfield State Hospital, Sykesville, Maryland Date signed: 4-18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

03811

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 yr., 1 mo., 7 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 18 yr., 1 mo., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William E. Geary

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1862

8. AGE: Years	Months	Days	If less than one day
83			hrs. min.

9. Birthplace: Washington County, Maryland (Town, county, and state)
10. Usual occupation: Liveryman
11. Industry or business:

FATHER
12. Name: Jonas Geary
13. Birthplace: Ireland

MOTHER
14. Maiden name: - - -
15. Birthplace: Ireland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 28, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Hagerstown, Md.

18. Funeral director: C. M. Shuler
Address: Hagerstown, Md.

19. April 25 1945 (Date rec'd by registrar) C. Harry Wine Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1945 at 2:45a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1 1943 to April 25 1945 and that I last saw him alive on April 24 1945

Immediate cause of death	DURATION
Arteriosclerosis	7 years
Due to	
Due to	
Other conditions: Manic-depressive psychosis, mixed type	36 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 4-25-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

03812

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years, 13 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 years, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Airhart Green

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 4, 1850

8. AGE: Years	Months	Days	If less than one day
94	11	10	..... hrs. ..... min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business

FATHER
12. Name: Louis Green
13. Birthplace: Md.

MOTHER
14. Maiden name: Nancy Miller
15. Birthplace: Md.

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 17-1945 (month) (day) (year)
Cemetery or crematory: Liberty Cemetery
Location: Rural Westminster
18. Funeral director: H Bankard & Son
Address: Westminster, Md.

19. April 14 1945 (Date rec'd by registrar) C. Henry Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14 1945 at 3:50a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 1943 to April 14 1945 and that I last saw him alive on April 13 1945

Immediate cause of death	DURATION
Senility	12 yrs.
Due to: Arteriosclerosis, prior to	1943
Due to:	
Other conditions: Senile psychosis, simple deterioration prior to	1943

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M.D. or other
Address: Sykesville, Maryland Date signed: 4-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03813

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 yr., 2 mo., 5 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 36 yr., 2 mo., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Frederick W. Guerth

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): about age 70

8. AGE: Years	Months	Days	If less than one day
about age 70			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Printer
11. Industry or business

FATHER
12. Name: Henry Guerth
13. Birthplace: Germany

MOTHER
14. Maiden name: Caroline Struth
15. Birthplace: Germany

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 6 1945 (month) (day) (year)
Cemetery or crematory: Baltimore Co.
Location: Balto. Md.
18. Funeral director: John W. Leufel
Address: 8 & W. Fayette St. Baltimore

19. April 4 1945 C. Henry Ward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4, 1945, at 10:00a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943, to April 4 1945 and that I last saw him alive on April 3 1945

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	16 mo.
Due to:	
Due to:	
Other conditions: Dementia precox, paranoid type	38 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M.D. or other
Address: Sykesville, Maryland Date signed 4-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03814

Reg. Diat. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Over 3

Hospital, Institution, or street address where death occurred: Springfield State Hosp.

How long in hospital or institution? 4 mos 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 3344 Belvedere Ave (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Louis Hackerman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept 18 - 1902

8. AGE: Years: 43 | Months: 1 | Days: 17 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Balto (Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER — 12. Name: Frank Hackerman

13. Birthplace: Germany

MOTHER — 14. Maiden name: Hannie Goldberg

15. Birthplace: Russia

16. Informant: Harold Hackerman

Address: 3344 Belvedere Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 8, 1945 (month) (day) (year)

Cemetery or crematory: Hebrew Cemetery

Location: Balto. Md.

18. Funeral director: Jack Lewis Inc

Address: 2100 Eutaw Place

19. April 7 1945 (Date rec'd by registrar) C. Harry Dew Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7th 1945 at 2.30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 19th 1944 to April 7th 1945

and that I last saw him alive on April 6th 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1 hr
Due to	
Epilepsy	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. J. Gaston M. D. or other

Address: Sykesville Md. Date signed: 4/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

03815

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:

County: Carroll County

City or town: Union Bridge, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Shirley Elaine Hark

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr 9- 45

8. AGE: Years 1 | Months 9 | Days 28 | If less than one day ..... hrs. ..... min.

9. Birthplace Union Bridge Carroll Co Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Orville Clark
13. Birthplace Union Bridge Md

MOTHER
14. Maiden name Lucille Mary Ann Hark
15. Birthplace Near New Windsor, Md.

16. Informant Lucille Mary Ann Hark
Address Union Bridge, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/10/45 (mo.) (day) (year)

Cemetery or crematory Mt Olive

Location Near New Windsor Md

18. Funeral director Raymond K. Knight

Address Union Bridge Md

19. April 10, 1945 (Date rec'd by registrar) Leslie D. Repp Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....

and that I last saw h... alive on ..... 19 .....

Immediate cause of death Partial Cremation —

	DURATION
Due to Flame burning down	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Apr 9-1945

Where did injury occur? Union Bridge (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Flame burning down Injured at work?

23. SIGNATURE James P. Mark, Deputy Medical Examiner M. D. or other

Address New Windsor Md Date signed Apr 10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15

03816

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yrs, 10 mos, 22 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 13 yrs, 10 mos, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montg'y

City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Margaret Harris

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife: Jr

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 18th - 1877

8. AGE: Years 67 | Months 9 | Days 23 | If less than one day: hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Dependent.

11. Industry or business:

FATHER — 12. Name: Eberle F Harris

13. Birthplace: Md

MOTHER — 14. Maiden name: Margaret Dutrow

15. Birthplace: Md

16. Informant: James P Harris

Address: 50 P Seward Square S E Washington D C

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/13/45 (month) (day) (year)

Cemetery or crematory: Indiana Cemetery

Location: Mt Airy Md

18. Funeral director: E C Gaither

Address: Gaithersburg Md

19. April 12 1945 (Date rec'd by registrar) C Henry Beer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11th 1945 at 6-30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19th 1931, to April 11th 1945 and that I last saw her alive on April 11th 1945

Immediate cause of death	DURATION
Intestinal Obstruction	4 d.
Due to Adhesions, probably tuberculous.	
Due to Chronic Adherent Peritonitis	6 weeks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Gaston M.D. M. D. or other

Address: Sykesville Md Date signed: 4/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03817

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 9 months, 13 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Harwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: LEROY JOHNSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 1, 1927

8. AGE: Years	Months	Days	If less than one day
18	2	9	hrs. min.

9. Birthplace: Davidsonville, Md.
(Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business:
FATHER 12. Name: John Johnson
13. Birthplace: Davidsonville, Md.
MOTHER 14. Maiden name: Pricella Parker
15. Birthplace: Bayard, Maryland
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 13 1945 (month) (day) (year)
Cemetery or crematory: Holsum Chapel
Location: Lothian Md.
16. Funeral director: Burnal Hardesty
Address: Galesville Md
19. April 10, 19 45 (Date rec'd by registrar) Albert C. Swanson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10, 1945, at 10:00 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28, 1943 to April 10, 1945 and that I last saw him alive on April 10, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1943
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 4-10-45

(M) MARGIN RESERVED FOR BINDING (I) (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03818

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs. 0 mo. 15 da.
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 8 yrs. 0 mo. 15 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 328 S. Newkirk Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARY JONES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) (mo and da unk) 1911

8. AGE: Years	Months	Days	If less than one day
34			hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: William Jones
13. Birthplace: Kentucky

MOTHER
14. Maiden name: Margaret Reed
15. Birthplace: Pennsylvania

16. Informant: Hospital Records
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 4, 1945 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cem.
Location: Sykesville, Md.

18. Funeral director: C. Harry Wlew
Address: Sykesville, Md

19. May 4 1945 (Date rec'd by registrar) C. Harry Wlew Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30, 1945 at 11.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 26, 1937 to April 30 1945
and that I last saw her alive on Apr. 30 1945

Immediate cause of death	DURATION
Carcinoma of the uterine cervix	2 yrs.
Due to:	
Due to:	
Other conditions: Schizophrenia	8yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

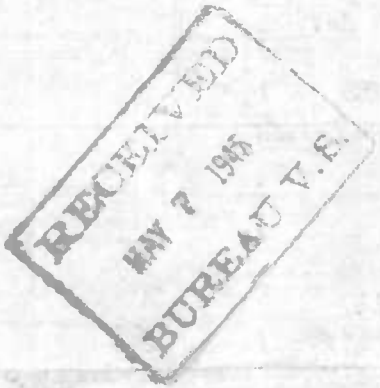
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Maud M. Rees M.D.
M. D. or other
Address: Sykesville Md. Date signed 4-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
MAY 7 1965
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03819

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 2 mos 24 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs 1 mo 24 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Cecelia Keil

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1877

8. AGE: Years: 67 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland
(Town, county, or state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Martin Kane
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Kelly
15. Birthplace: Ireland

16. Informant: Mrs. Henry Koerner

Address: 507 N Wolfe St. Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 2 1945 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Henry Ebert

Address: Sykesville, Md.

19. April 2 1945 (Date rec'd by registrar) C. Henry Ebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1st 1945 at 3.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6th 1943 to April 1st 1945 and that I last saw her alive on April 1st 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 wk
Due to Chr. Myocarditis	3 yr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. F. Gaston M.D. M. D. or other

Address: Sykesville Md. Date signed: 4/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-d)

03820

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

1. PLACE OF DEATH:
County Carroll
City or town Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years 6 months 5 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 years 6 months 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Lonaconing, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Douglas Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME DENNIS KELLY

3.(b) Social Security Number 215-20-7332.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Olive Kelly
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) October 4, 1903

8. AGE: Years	Months	Days	If less than one day
41	6		..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Bartender
11. Industry or business

FATHER
12. Name James Kelly
13. Birthplace Nova Scotia

MOTHER
14. Maiden name Rose Doolan
15. Birthplace England

18. Informant Mrs. Olive Kelly, wife
Address Douglas Avenue, Lonaconing, Md.

17. Burial (Burial, cremation, or removal) Which?) Date thereof April 7, 1945 (month) (day) (year)
Cemetery or crematory Lonaconing
Location Lonaconing, Md.
18. Funeral director C. Harry Eiler
Address Sykesville, Md.

19. April 4 1945 C. Harry Eiler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION Prior to

20. DATE OF DEATH April 4 1945 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage	
Due to Severed blood vessels neck and wrist.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of Apr 4-45
Where did injury occur? Sykesville (City or town) Carroll (County) Md (State)
Injured at home, farm, industry, public place (where?) Springfield State Hospital
Means of injury Razor blade Injured at work? No.

23. SIGNATURE James J. Shand, Deputy Medical Examiner M. D. or other
Address Glen Burnie Md Date signed 4/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on FILM No. G 95 JUN 5 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

03821

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 35 S. Fulton ave. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: CHARLOTTE KLINE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Charles Kline

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 5, 1909

8. AGE: Years	Months	Days	If less than one day
35 ~~34~~	8	13	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Charles F. Kirner

13. Birthplace: Md.

MOTHER 14. Maiden name: Anna M. Mackey

15. Birthplace: Md.

16. Informant: Mr. Charles F. Kirner

Address: 35 S. Fulton ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 21, 1945 (month) (day) (year)

Cemetery or crematory: Western Cemetery

Location: Baltimore, Md.

18. Funeral director: F. B. Wilbert & Son

Address: Eutaw & Lemmon Sts.

19. April 19 1945 (Date rec'd by registrar) C. Harry Hess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 1945, at 6 25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14 1945, to April 18 1945 and that I last saw her alive on April 18 1945

Immediate cause of death	DURATION
Metastatic spread of Carcinoma	3 mos.
Due to: Carcinoma of breast (rt.)	1 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Edward F. Kerman M. D. or other

Address: Sykesville, Md Date signed 4-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

04336

Reg. Dist. No. 80

1. PLACE OF DEATH:
County: Carroll
City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Arthur St. Clair Lambert

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Nellie E. Lambert
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 12 - 1876

8. AGE: Years	Months	Days	If less than one day
68	11	22	..... hrs. ..... min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: John W. Lambert
13. Birthplace: Maryland

MOTHER
14. Maiden name: Emily Lambert
15. Birthplace: Pa.

16. Informant: Mr. Roswell C. Lambert
Address: New Windsor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 6-1945 (month) (day) (year)
Cemetery or crematory: Winters Cemetery
Location: Union Bridge Road

18. Funeral director: H. H. Hartsuff & Son
Union Bridge & New Windsor Md.

19. Apr 6 1945 (Date rec'd by registrar) Emma S. Bendel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 1945 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Arteriosclerotic C-V disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: James F. Monk Deputy Medical Examiner
M. D. or other
Address: New Windsor Md. Date signed 4/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

03822

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 71 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural - Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Louis McHenry Little

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 19 - 1873

8. AGE: Years	Months	Days	If less than one day
71	10	14	..... hrs. ..... min.

9. Birthplace Warfieldsburg Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Carpenter, ret.
11. Industry or business
FATHER 12. Name Jacob H. Little
13. Birthplace Md.
MOTHER 14. Maiden name Emma M. Dupt
15. Birthplace Md.
16. Informant Charles E. Little
Address Westminster Md. R.D. #4
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 6 1945 (month) (day) (year)
Cemetery or crematory Kriders cemetery
Location Westminster Md.
18. Funeral director A.B. Bankard & Son
Address Westminster Md.
19. ..... 19.. 45 L.A. Masters
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1945 - at 12:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1945 to April 3 1945
and that I last saw h.... alive on April 3 1945
Immediate cause of death Emphysema & Hypostatic Pulmonary Congestion & Myocardial Degeneration — DURATION 3 da
Due to
Due to
Other conditions Cholecystitis
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Glenn Fleischer M. D. or other
Address Westminster Md. Date signed 4/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

03823

Reg. Diat. No. 8th

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ida Elizabeth Lovell

3. (b) Social Security Number: None

4. Sex: Female | 5. Color or race: white | 6.(a) Single, married, widowed, or divorced: widow

6.(b) Name of husband ~~or wife~~: Wm. D. Lovell Sr.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 31 - 1862

8. AGE: Years: 83 | Months: 0 | Days: 7 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll County, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Jacob Shoemaker

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Shoemaker

MOTHER — 15. Birthplace: Maryland

16. Informant: Wm. D. Lovell Jr.

Address: New Windsor Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 11-1945 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cem.

Location: Uniontown Road

18. Funeral director: D. D. Harbert & Sons

Address: Union Bridge & New Windsor Md

19. April 10 1945 (Date rec'd by registrar) Emma S. Bunker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 1945 at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 1944 to April 7 1945 and that I last saw h.. alive on April 4 1945

Immediate cause of death: Arteriosclerotic C-D disease — DURATION

Due to:

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T. Howard M. D. M. D. or other

Address: New Windsor Md Date signed: April 8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

03824

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs 2 mos 20 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 14 yrs 2 mos 20 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Mt. Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1426 Forge Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anna Elizabeth Nash

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed.

6.(b) Name of husband or wife Alfred Nash

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 20, 1860

8. AGE:

Years	Months	Days	If less than one day
84	3	15	..... hrs. ..... min.

9. Birthplace England (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER

12. Name James Horsford

13. Birthplace England

MOTHER

14. Maiden name Lucilla Harwood

15. Birthplace England

16. Informant Hospital Records

Address Sykesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/9/45 (month) (day) (year)

Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md.

18. Funeral director Wm. J. Tickner & Sons

Address Balto., Md.

19. 4/9 (Date rec'd by registrar) 1945 R. V. Hdnell M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1945, at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 26, 1931 to Apr 5, 1945 and that I last saw h alive on Apr 5, 1945

	DURATION
Immediate cause of death	
General Arteriosclerosis	14 yrs.
Due to	
Due to	
Other conditions Paralysis agitans	15 yrs.
Cerebral Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Maud M. Pues M.D. M. D. or other

Address Sykesville, Md. Date signed 4-4-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03825

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 8 days

Hospital, Institution, or street address where death occurred: Maryland Tbc. San. (Colored Branch) Henryton, Md.

How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 108 S. Bond Street

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME CURTIS McRAE

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COLORED	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 29, 1924

8. AGE: Years	Months	Days	If less than one day
20	8	29	hrs. min.

9. Birthplace Bennettsville, S.C. (Town, county, and state)

10. Usual occupation Merchant Seaman

11. Industry or business --

FATHER 12. Name Lee McRae

13. Birthplace Unknown

MOTHER 14. Maiden name Amease Preete

15. Birthplace Unknown

16. Informant Reuben Hoffman, M.D.

Address Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1 1945 (month) (day) (year)

Cemetery or crematory Mt. Calvary

Location Balto. Md.

18. Funeral director Elroy O. Wilson

Address 1000 Brantley ave

19. Apr. 28 1945 (Date rec'd by registrar) Albert R. Swanberg Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1945 at 10:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1945 to April 28 1945 and that I last saw him alive on April 28 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	6/27/44
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Md. Date signed 4-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03826

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 6 mos. 27 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 5 yrs. 6 mos. 27 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME
Hester Middlebrooks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 30, 1922

8. AGE:	Years	Months	Days	If less than one day
	22	10	18	...hrs. ...min.

9. Birthplace: Caroline County, Virginia
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Harry Middlebrooks
13. Birthplace: Caroline County, Virginia

MOTHER
14. Maiden name: Annie Collins
15. Birthplace: West Point, Virginia

16. Informant: Mr. Harry Middlebrooks
Address: 2815 Maisel Ave., Baltimore, Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof April 20, 1945 (month) (day) (year)

Cemetery or crematory: Glen Haven Memorial Cem.

Location: Mt. Glenburnie, A. R. Co., Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. April 18, 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17, 1945, at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 6, 1944, to April 17, 1945 and that I last saw her alive on April 16, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 months
Due to	
Due to	
Other conditions: Mental Deficiency	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Edward F. Kernan M. D. ~~or other~~

Address: Sykesville, Md Date signed 4-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1705)

CERTIFICATE OF DEATH

03827

Reg. Diat. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Manchester R.D.1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Year 3 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Manchester R.D. 1
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Roy James Miller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 25 1937

8. AGE:

Years	Months	Days	If less than one day
7	11	19	hrs. min.

9. Birthplace Hanover, PA.
(Town, county, and state)

10. Usual occupation School Boy

11. Industry or business School Boy

FATHER
12. Name Walter L. Miller

13. Birthplace Adams Co. PA.

MOTHER
14. Maiden name Naomi Orl.

15. Birthplace Hanover. PA.

16. Informant Walter L. Miller

Address Manchester, Md. R.D.1

17. Removal for Burial Date thereof April 17 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Christ Church Cemetery

Location Near Littlestown, PA.

18. Funeral director J. M. Little & Son

Address Littlestown, PA RURAL

19. Apr. 14 1945 Mrs. W. R. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1945 at 3:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Fracture Skull	
Due to	
Due to	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Apr 14-45

Where did injury occur? Manchester (Carroll) Maryland
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home - farm

Means of injury Struck head with wrench Injured at work? No

Catching hog

23. SIGNATURE James A. Shank Deputy Medical Examiner
M. D. or other

Address Westminster Md. Date signed 4/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03828

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs 11 mos

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 12 yrs 11 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Catherine Orheiser

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): April 14th - 1915

8. AGE: Years 30 Months — Days 8 If less than one day ... hrs. ... min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER 12. Name: Peter Orheiser

13. Birthplace: Baltimore

MOTHER 14. Maiden name: Catherine Miller

15. Birthplace: Baltimore

16. Informant: Mrs. Catherine Orheiser

Address: Severn Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/26/45 (month) (day) (year)

Cemetery or crematory: Holy Rosary

Location: Camden Hill Rd.

18. Funeral director: M. W. E. Gould & Sons

Address: Lombard & Hunt Sts.

19. 4/24/45 (Date rec'd by registrar) H. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 19 45 at 8-30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21st 1932 to April 22 1945 and that I last saw h e alive on April 22 1945

Immediate cause of death	DURATION
Chronic Backward Endocarditis	3
Due to Epilepsy	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: W. F. Haston M.D. (M. D. or other)

Address: Sykesville Md. Date signed 4/22/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03829

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 951 Homestead Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Catherine Ray

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 10, 1878

8. AGE: Years	Months	Days	If less than one day
66	9	22	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Thomas Gordan
13. Birthplace: Ireland

MOTHER
14. Maiden name: Margaret Bradley
15. Birthplace: Ireland

16. Informant: Miss Elsie M. Ray, daughter
Address: 951 Homestead Street, Balto., Md.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof: 4/7/45 (month) (day) (year)
Cemetery or ~~crematory~~: St. Marys - Govans
Location: Balto. Md.

18. Funeral director: William Cook Inc
Address: 1217 St. Paul St.

19. Filed 4 1945 (Date rec'd by registrar) C. Gary Weaver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4 1945 at 11:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 1945, to April 4 1945 and that I last saw h... on ...alive on April 4 1945

Immediate cause of death	DURATION
Bilateral Bronchopneumonia	4 days
Due to	
Due to	
Other conditions: Psychosis & cerebral arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward F. Kernan M. D. or other
Address: Sykesville, Md. Date signed: 4-4-45

M — MARGIN RESERVED FOR BINDING

I — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T — VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

03830

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 28 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 119 Fleming Drive
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: LORETTA REED

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 18, 1939

8. AGE: Years	Months	Days	If less than one day
5	11	24	hrs. min.

9. Birthplace: Appomattox, Virginia (Town, county, and state)
10. Usual occupation: none
11. Industry or business:

FATHER
12. Name: --
13. Birthplace: --

MOTHER
14. Maiden name: Corene Reed
15. Birthplace: Appomattox, Virginia

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. SHIPPED (Burial, cremation, or removal. Which?) Date thereof 4-14-45 (month) (day) (year)
Cemetery or crematory: Stone Wall cemty.
Location: Appomattox Va.
18. Funeral director: William A Jackson
Address: 916 Penn Ave
19. April 11, 45 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11, 45, at 8:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14, 44 to April 11, 45
and that I last saw her alive on April 11, 45

	DURATION
Immediate cause of death: Tuberculous Meningitis	March 29
Due to: Primary tuberculosis	1945
Due to:	March 1944
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 4-11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19

CERTIFICATE OF DEATH

03831

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs., 1 month, 10 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium, Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Newark
(If outside city or town limits, write RURAL and give nearest town)
Street No. na
(If rural, give LOCATION)
2.(a) If veteran, name war: na ✓

3. (a) FULL NAME: MARY ELIZABETH RICHARDS

3. (b) Social Security Number: na

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

8.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 26, 1920

8. AGE:

Years	Months	Days	If less than one day
24	10	17	..... hrs. ..... min.

9. Birthplace: Worcester County, Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: John Richards
13. Birthplace: Worcester County, Md.

MOTHER
14. Maiden name: Minnie Bethards
15. Birthplace: Worcester County, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 17, 1945 (month) (day) (year)
Cemetery or crematory: Newark
Location: Newark Md.
18. Funeral director: James F. Stewart
Address: Baltimore Md.

18. April 12, 19 45 (Date rec'd by registrar) Albert R. Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12, 1945 at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2, 1941 to April 12, 1945 and that I last saw her alive on April 12, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1936
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 4-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03832

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2329 Madison Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CATHERINE ROSS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Benjamin Ross
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): July 17, 1920

8. AGE: Years	Months	Days	If less than one day
24	9	1	...hrs. ...min.

8. Birthplace: Ellicott City, Md. (Town, county, and state)
10. Usual occupation: In training to be a Nurse
11. Industry or business:

FATHER
12. Name: Joshua Bruce
13. Birthplace: Ellicott City, Md.

MOTHER
14. Maiden name: Hattie Dorsey
15. Birthplace: Ellicott City, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 21, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore, Md.

18. Funeral director: Mrs. George A. Stall
Address: 1631 Druid Hill Ave.

19. April 18, 19 45 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18, 19 45, at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13, 1945 to April 18, 1945 and that I last saw her alive on April 18, 1945

Immediate cause of death: Tuberculous Peritonitis — DURATION: March 1945
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 4-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

03833

CERTIFICATE OF DEATH

Reg. Diat. No. 82

1. PLACE OF DEATH:
County: Carroll
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(n) If veteran, name war

3. (a) FULL NAME: AUGUSTUS SHIPLEY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ada Shipley (dec.)
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 5, 1863

8. AGE: Years	Months	Days	If less than one day
82	3	12	hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)
10. Usual occupation: Telegraph Operator (retired)
11. Industry or business: Railroad

FATHER
12. Name: Bradley G. Shipley
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary V. Ford
15. Birthplace: Maryland

16. Informant: Miss Bessie Shipley
Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation~~, or removal. Which?) Date thereof 4--20--45 (month) (day) (year)
Cemetery or ~~crematory~~: Pine Grove
Location: Mt. Airy, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. Apr. 19 (Date rec'd by registrar) 19 45 Thos D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17, 19 45, at 5:00P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 37, to April 17, 19 45
and that I last saw him alive on April 16 19 45

Immediate cause of death: Angina Pectoris — DURATION: 2 mo
Due to: Coronary Sclerosis — ?
Due to:
Other conditions: Chr. Myocarditis — yrs ?
Chr. Hypertension — yrs ?
(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: J Stanley Grabill M. D. or other
Address: Mt Airy, Md Date signed 4/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

03834

CERTIFICATE OF DEATH

Reg. Diat. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? several hours

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Middleburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Clayarchus E.Six

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

8.(b) Name of husband or wife Mable Pohle Six

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan.21,1887

8. AGE: Years	Months	Days	If less than one day
58	3	6	..... hrs. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Storekeeper & Postmaster

11. Industry or business

FATHER 12. Name William Six

13. Birthplace Md

MOTHER 14. Maiden name Catherine Stambaugh

15. Birthplace Md

16. Informant Mrs.Mable Six

Address Middleburg,Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr.30,1945 (month) (day) (year)

Cemetery or crematory Keysville

Location Keysville,Md.

18. Funeral director C.O.FUSS & SON

Address Taneytown,Md.

19 April 29 1945 Ethele M Mehring Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION Between

20. DATE OF DEATH April 27 1945 at 4-7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Coronary disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE James T Mook Deputy Medical Examiner M. D. or other

Address New Windsor Md Date signed 4/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03835

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months 20 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 6 months 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore, Maryland (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Edward C. Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widow

6.(b) Name of husband or wife: Mary Kraff

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1873

8. AGE:	Years	Months	Days	If less than one day
	72			..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business

FATHER — 12. Name: John Smith

13. Birthplace: Germany

MOTHER — 14. Maiden name: Caroline ----

15. Birthplace: Germany

16. Informant: Mrs. Walter A. Watts, Grandniece

Address: 4312 Berger Avenue, Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3, 1945 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. April 3 1945 C. Harry Weer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1 1945 at 11 25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-11 1944 to 4-1 1945 and that I last saw him alive on April 1 1945

Immediate cause of death	DURATION
Bilateral Bronchopneumonia	8 days
following	
Pre-frontal Lobotomy	
Due to	
Other conditions	
Involutional Melancholia	13 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Edward F. Kerman M. D. or other

Address: Sykesville, Md. Date signed 4-2-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

03836

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 2 mo., 26 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 yr., 2 mo., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John William Snyder

3.(b) Social Security Number: 194-01-1018

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	unknown

6.(b) Name of husband or wife: Anna May Morland
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 27, 1904

8. AGE: Years	Months	Days	If less than one day
40	6	1	hrs. min.

9. Birthplace: Altoona, Pennsylvania (Town, county, and state)
10. Usual occupation: Painter
11. Industry or business

FATHER
12. Name: Walter Snyder (Walter James S.)
13. Birthplace: Illinois

MOTHER
14. Maiden name: Maude Irene Gardner
15. Birthplace: Pennsylvania

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1, 1945 (month) (day) (year)
Cemetery or crematory: Alton Rest Cemetery
Location: Hollidaysburg, Pa.
18. Funeral director: C. Harry Wenz
Address: Sykesville, Md.

19. April 28 1945 (Date rec'd by registrar) C. Harry Wenz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28 1945 at 6:20a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9 1944 to April 28 1945 and that I last saw him alive on April 27 1945

Immediate cause of death	DURATION
General Paralysis of the	
insane, prior to December	1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed 4-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03837

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll County
City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: City County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3106 Southern Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Leonard C. Staley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Hattie May Beall
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 28, 1879

8. AGE: Years	Months	Days	If less than one day
65	7	4	..... hrs. ..... min.

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:
FATHER 12. Name: William H. Staley
FATHER 13. Birthplace: West Virginia
MOTHER 14. Maiden name: Sarah Chaplain
MOTHER 15. Birthplace: West Virginia
16. Informant: Mrs. Hattie May Staley, wife
Address: 3106 Southern Avenue, Balto., Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 6, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Gov. Methodist Cem.
Location: Harford Co. Md.
18. Funeral director: Leonard J. Reuck
Address: 5305 Harford Rd.
19. April 3 1945 (Date rec'd by registrar) C. Henry Edwards Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 1945 at 2:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 1945 to April 3 1945 and that I last saw h... im... alive on April 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 yrs
Other conditions: Psychosis with cerebral arteriosclerosis.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Edward F. Kerman M. D. or other
Address: Sykesville, Md Date signed 4-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03838

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 22 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution?
Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1523 Barclay St.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: TILTON BRAXTON STOKES

3.(b) Social Security Number: 213-01-3957

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 5, 1905

8. AGE: Years	Months	Days	If less than one day
39	8	9	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business: Unknown
FATHER 12. Name: Henry Stokes
FATHER 13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Eleanor Williams
MOTHER 15. Birthplace: Baltimore, Md.
16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 19-1945 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Brooklyn
18. Funeral director: Va Brooks Pinkett
Address: 1463 N. Carey St
19. April 14, 19 45 (Date rec'd by registrar) Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14, 1945 at 9.00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb., 23, 1945 to April 14, 1945 and that I last saw him alive on April 14, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov., 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other
Address: Henryton, Md. Date signed 4/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03839 P.

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 23 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 math, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2506 E. Eager Street
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Albert Valentime (Valentini)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rose Sales Valentine
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 5, 1891

8. AGE:	Years	Months	Days	If less than one day
	53	11	25	..... hrs. ..... min.

9. Birthplace: Italy
(Town, county, and state)
10. Usual occupation: Tailor
11. Industry or business:

FATHER
12. Name: Nick Valentine
13. Birthplace: Italy

MOTHER
14. Maiden name: Elise Borega
15. Birthplace: Italy

16. Informant: Mrs. Rose Sales Valentine, wife
Address: 2409 Roland Avenue, Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/3/45 (month) (day) (year)
Cemetery or crematory: ~~XXX~~ St. Vincent's
Location: Baltimore, Maryland.
18. Funeral director: Charles E. Schimunek
Address: 2601 E. Madison Street

19. 5/2 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 19 45 5:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 19 45, to April 30 19 45 and that I last saw h. alive on April 29 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions: Portal Cirrhosis, Syphilis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Edward F. Kerman M. D. or other
Address: Sykesville, Md. Date signed 4-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

03840

Reg. Dist. No. 8d

1. PLACE OF DEATH:

County Carroll

City or town New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ years

Hospital, Institution, or street address where death occurred:

Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Isabella Reaver Wheat

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife Eugene C. Wheat

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 17, 1886

8. AGE: Years 58 | Months 8 | Days 17 | If less than one day ... hrs. ... min.

9. Birthplace Fred Co. Md. New Windsor

(Town, county, and state)

10. Usual occupation home-wife

11. Industry or business

FATHER 12. Name M. Hamilton Reaver

13. Birthplace Md.

MOTHER 14. Maiden name Florence Harris

15. Birthplace Md.

16. Informant Mrs. Eugene C. Wheat

Address New Windsor Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/7/45 (month) (day) (year)

Cemetery or crematory Bethel Cemetery

Location Sams Creek near New Windsor Carroll Co. Md.

18. Funeral director J. S. Myers Jr.

Address Westminster, Md.

19. April 5 1945 (Date rec'd by registrar) Emer D Mudd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1945, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 14 1944 to April 4 1945 and that I last saw her alive on April 4 1945

	DURATION
Immediate cause of death (a) Arteriosclerotic Intoxication	
Due to (b) Arteriosclerotic C-V disease	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Monroe M. D. or other

Address New Windsor Md Date signed April 5 1945

M

I

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03841

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 8 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 665 Stirling St.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: HUGH WHITE

3.(b) Social Security Number: 213-09-3365

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Sophie White
6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): September 25, 1892

8. AGE: Years	Months	Days	If less than one day
52	6	15	....hrs. ....min.

9. Birthplace: Tallahassee, Florida (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Monroe White
13. Birthplace: Unknown

MOTHER
14. Maiden name: Liza ?
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof April 12 1945 (month) (day) (year)
Cemetery or crematory Mt. Calvary Cem.
Location Annapolis Road.

18. Funeral director Mrs Robert Elliott & daughter
Address 1129 N. Caroline St.

19. April 9, 1945 (Date rec'd by registrar) Albert R. Swanborg Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1945, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1, 1944 to April 9, 1945 and that I last saw him alive on April 9, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE Reuben Hoffman M.D. M. D. or other
Address Henryton, Md. Date signed 4-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03842

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs 10 mos

Hospital, institution, or street address (if not in hospital or institution): Springfield State Hospital

How long in hospital or institution? 17 yrs 10 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Ethel Wilhelm

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Gordon Wilhelm

7. Birth date of deceased (mo., day, yr.): 1898 — B.(c) If alive, give age: years

8. AGE: Years: 47 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Dependent.

11. Industry or business:

FATHER — 12. Name: Henry Coffin

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sarah Brewer

15. Birthplace: Maryland

16. Informant: Gordon Wilhelm

Address: 917 Chase St Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 5, 1945 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Eiler

Address: Sykesville, Md.

19. April 5 1945 (Date rec'd by registrar) C. Harry Eiler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2d 1945 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1927 to April 2d 1945 and that I last saw h[illegible] alive on April 2d 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 da
Due to:	
Chronic Hypertension	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. J. Wooten M.D. M. D. or other

Address: Sykesville Md. Date signed: 4/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03843

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 2 months, 10 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1525 East Lombard St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARY ALICE WOMACK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 10, 1920

8. AGE: Years	Months	Days	If less than one day
25	2	15	hrs. min.

9. Birthplace: Scottsburg, Va. (Town, county, and state)
10. Usual occupation: Laundry Worker
11. Industry or business:

FATHER
12. Name: Charles Womack
13. Birthplace: Virginia

MOTHER
14. Maiden name: Bessie Elvert
15. Birthplace: Virginia

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Shipped (Burial, cremation, or removal. Which?) Date thereof April 25-1945 (month) (day) (year)
Cemetery or crematory:
Location: Scotts Bury Va
16. Funeral director: Rayner Sanders
Address: 1412 E Pusta St.

19. April 25, 19 45 (Date rec'd by registrar) Albert R. Swanbeck Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25, 19 45 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 15, 19 44 to April 25, 19 45 and that I last saw her alive on April 25, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 4-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on FILM No. G 95 MAY 28 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

CERTIFICATE OF DEATH

03844

Reg. Diat. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Bachmans Valley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 77 - 5 - 19
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Bachmans Valley
(If outside city or town limits, write RURAL and give nearest town)
Street No. Postmark R.D. 3
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lydia Ann Yingling

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 21 - 1877

8. AGE: Years	Months	Days	If less than one day
67 -77-	5	19	..... hrs. ..... min.

9. Birthplace Bachmans Valley, Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name John Thomas Yingling
13. Birthplace Md.
MOTHER 14. Maiden name Louisa Ickes
15. Birthplace New Oxford, Pa.
16. Informant Vivia Yingling
Address Westminster, Md. R.D. # 3
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 12 1945 (month) (day) (year)
Cemetery or crematory Luther Miller Cemetery
Location Bachmans Valley, Md.
18. Funeral director H. Bankard & Son
Address Westminster, Md.
19. 4/1 1945 J. K. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1945 at 8:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 1945, to April 10 1945
and that I last saw her alive on April 7 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	Weeks 2 Days
Due to Cardiovascular Renal Disease &	
Due to Hypertension & Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other
Address Westminster, Md. Date signed 4/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

03845

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 29 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 2 months, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Buck Lodge

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Samuel Young

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 27, 1873

8. AGE: Years	Months	Days	If less than one day
71	6	19	..... hrs. ..... min.

9. Birthplace Middletown, Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Crawford F. Young

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Ellen Pretzman

15. Birthplace Pennsylvania

16. Informant Mrs. Zovie Wade, sister

Address Buck Lodge, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-18-45 (month) (day) (year)

Cemetery ~~or crematory~~ Boyd's Presbyterian

Location Boyds, Montgomery Co. Md.

18. Funeral director W. B. Hilton

Address Barnesville Md.

19. April 16 19 45 (Date rec'd by registrar) C. Harry Wine Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 19 45 at 12:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 17 19 45 to April 16 19 45 and that I last saw h... i.m. alive on April 15 19 45

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to Generalized Arteriosclerosis	?
Due to	.....
Other conditions Senile Psychosis	.....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE Edward F. Kerman M. D. or other

Address Sykesville, Md. Date signed 4-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15